Perspectives of Young Child Abuse Survivors on Confidentiality

Matthew, Laurie; Barron, Ian; Hodson, Ann

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Abstract

The current systematic narrative literature review sought to discover young child sexual abuse (CSA) survivors, unknown to child protection services, views on confidentiality. Due to the paucity of research on young CSA survivors, the review was widened to include users of sexual health services. Seventeen databases were searched and results were refined by reading titles, abstracts then followed by full text. Analysis involved an exploratory interpretist approach to identify conceptual themes and research methodologies.

Fifteen published papers were identified. Research methods were narrow and included surveys, interviews, and focus groups, with limited youth participation. In addition to the theme of confidentiality essential to this study, themes identified included - needing accurate information about services, the importance of someone non-judgemental to talk to, control over decisions affecting their lives, and better access to services. Studies indicated young people were fearful of child protection involvement. In conclusion, studies suggest young survivors unknown to child protection services need a higher level of confidential services and more control of their information. Further research involving young survivors in participatory methods is needed to explore issues of confidentiality, survivor participation, and fear of child protection agencies.

Keywords: confidentiality; *child sexual abuse; young people; privacy; participatory; sexual health services*

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Perspectives of young child abuse survivors on confidentiality: An exploratory literature review

The Human Rights Act (1998) not only aims to protect children from child sexual abuse (CSA) and the resultant negative consequences of harm, but also includes the right to confidentiality (Article 8). Such legislation defines confidentiality as the "…right to respect for his or her private and family life, his or her home and his or her correspondence" (p.23). Confidentiality, also refers to a relationship of trust during which a person shares private information, with the expectation it will be kept private (Purtilo, 1999). Within the context of professional services, Daniel and Kitchener (2000) define confidentiality as "a commitment made by a professional that non-public information will not be disclosed to a third party without consent" (p78). Koggel (2003) states, "the protection of confidentiality is one vehicle for creating relationships that enable free speech and promote self-development" (p.121). Confidentiality is regarded as necessary for disclosure and reflection and Bisman (2008) explains that confidentiality allows opportunity to discuss difficult issues with less risk.

In the UK confidentiality is upheld and further defined by common law and statute (Pattenden & Sheehan, 2016). Confidentiality is a fundamental aspect for professional practice across agencies including social services, health, education and police; and all have guidelines, and codes of conduct to guide staff, and reassure the public about the degree, and limits of confidentiality (Fisher, 2008).

Confidentiality and young people

If young people are not afforded confidentiality by child protection and other services, they may be unable to speak openly and frankly (McPherson, 2005). Studies suggest that the main reason young people do not seek help from professionals is due to the lack of confidentiality (Hallet, Murray & Punch, 2003). Lack of confidentiality is also one of the reasons young people fail to engage in services that seek to help them heal from traumas

(Jenkins, 2010). Specifically in relation to sexual health, Boonstra and Jones (2004) found that teenagers would stop using sexual health services if there were no confidentiality, but they would continue having sex. Finally, lack of confidentiality is one of the key issues preventing young survivors from disclosing abuse (Goodman-Brown, 2003).

The United Nations Convention on the Rights of the Child (UNCRC, 1989) upholds the right to privacy and confidentiality through Articles 12, 14, 16, 19 and 24. Young people's right to consent to medical treatment without parents' knowledge also implies the right to confidentiality (Mason & Laurie, 2006). For child protection and other services in the UK, both the Data Protection Act and Human Rights Act of 1998 uphold the right to confidentiality, but there can be tension between the right to privacy and the presumed need to intervene, in relation to abuse, underage sexual activity and crime. The Children Act 1989 and Sexual Offences Act 2003 require that information is gathered for child protection, however, according to Roche (2008) child welfare increasingly overrules rights with professionals having power to ignore privacy and other rights and share information when they perceive risk. Whether there is actual risk does not appear to need to be established (Roche, 2008).

In the UK, the local authority and police have a duty under the Children Act of 1989 to report and investigate child abuse. Employees typically have a contractual duty to report suspected abuse, sexual activity or crime. According to Stewart (2004), few countries have legislation that oblige people to report child abuse. In countries with mandatory abuse reporting laws, these do not always improve outcomes for children at risk, according to Harries and Clare (2002). Mandatory reporting of child abuse lacks evidence of protecting children (Rubin, 2016) and increasing legislation of abuse reporting leads to unnecessary erroneous reports, inability to respond and impaired investigations (DePasquale, 2017).

What is known about CSA

Definitions of CSA vary making prevalence rates difficult to estimate. Briere and Elliot (2003) for example define the age limit at eighteen, while others include ages below and above this cut-off (Arreola, Neilands, Pollack, Paul, & Catania, 2005; Chen, Dunne, &Han, 2004). Other researcher definitions include contact and non-contact sexual experience between a person under 18 (Pereda, Guilera, Forns & Gómez-Benito, 2009) and an adult or person at least 5 years older. Some definitions set CSA within the wider context of sexual exploitation (World Health Organisation, 2016). The current study uses the Scottish Government definition of CSA, which states that, "sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented" (National Guidance for Child Protection in Scotland, 2014, p.12).

Prevalence of CSA

Worldwide prevalence rates of CSA vary depending on definitions, populations studied, and methodologies used. A Canadian study by Cyr, Hébert, Tourigny, McDuff and Joly (2009) found 21.1% of females and 9.7% of males reported CSA and a UK study by Cawson, Wattam, Brooker and Kelly (2000) reported similar rates at 20% for females and 11% for males. Recent UK prevalence data (Radford et al., 2011) suggested that 11.3% of 18-24 year olds had experienced CSA while a Swedish study (Priebea & Svedin, 2008) that focused specifically on 18 year olds , found an exceptionally high prevalence rate of 81% for females and 69% for males. The high prevalence rate was possibly due to the wide definition of CSA used which included peer abuse, and also the anonymity of the study. Prevalence rates for children and young people with disabilities, have been found that are, eight times higher than the general population (Spencer et al., 2005). Rates vary widely dependent on the severity of disability (Wissink, van Vurt, Moonen, Stams & Hendriks, 2015). In short,

prevalence rates in studies are high but vary considerably across studies dependant on the age, gender, location, disability and research methodology.

In contrast, disclosure rates of CSA are low ({ HYPERLINK "https://www.sciencedirect.com/science/article/pii/S0145213416301259" \l "bib0245" }; { HYPERLINK "https://www.sciencedirect.com/science/article/pii/S0145213416301259" \l "bib0260" }), and frequently delayed ({ HYPERLINK "https://www.sciencedirect.com/science/article/pii/S0145213416301259" \l "bib0175" }; { HYPERLINK "https://www.sciencedirect.com/science/article/pii/S0145213416301259" \l "bib0215" }). It is estimated that between 30% and 80% of sexually abused children do not tell about abuse (Paine & Hansen, 2002; Smith Letourneau, Saunders, Kilpatrick, Resnick & Best, 2000). Indeed, Alaggia (2004) found that 58% of CSA survivors did not disclose until adulthood, with Somer and Szwarcberg (2001) discovering an average delay of 15 years, from time of abuse, to disclosure.

The negative impact of CSA on social functioning, mental, and physical health, maladaptive behaviours, such as substance abuse and relationships is well documented (Maniglio, 2009; Chen, Murad, Paras, Colbenson, Sattler & Goranson, 2010; Horvath, 2014; Domhardt, Munzer, Fegert & Goldbeck, 2015; Sneddon, Wager & Allnock, 2016). Mental health issues commonly associated with CSA include depression, eating disorders, PTSD, sleep disorders and suicide attempts (Chen et al., 2010; Horvath, 2014; Sneddon et al., 2016). According to Nelson (2016), long-term physical and mental health problems experienced by many CSA survivors is unacceptable, and “effective prevention and deterrence, and the best possible support, should at last become twin priorities for action” (p. 18).

What is known about young CSA survivors

Research with young CSA survivors known to authorities suggests CSA is associated with increased risk of suicide attempts (Yong, Lim & Yeo, 2018) and studies indicate

sexually abused children are higher risk than non-abused children of presenting with behaviour problems (Lewis McElroy, Harlaar & Runyan, 2016), posttraumatic stress, dissociation symptoms (Hébert, Langevin & Daigneault, 2016), and emotional dysregulation (Langevin, Cossette & Hebert, 2016). A review of CSA disclosure literature (Alaggia, Collin-Vezina & Lateef, 2017) found disclosure to be an ongoing process within a relational context; younger children and boys made fewer disclosures and accidental detection rather than purposeful disclosure was more likely in under 18's. Additionally, they found more barriers than facilitators to CSA disclosure identified in studies. An important barrier is the child's expectation of negative consequences for themselves (Malloy, Brubacher & Lamb, 2011).

Research with young CSA survivors unknown to authorities has indicated survivors had previously experienced other forms of abuse and that sexual abuse is perpetrated mainly by peers, friends and neighbours (Pereda, Abed & Guilera, 2016). Most children had disclosed to a friend and/or a parent with a minority disclosing to authorities (Lahtinen, Laitila, Korkman & Ellonen, 2018). The main reasons given for non-disclosure was that the children did not consider the sexual experience to be serious enough, or even abuse. It is possible that many children may not identify as CSA survivors due to lack of knowledge and level of cognitive and emotional development (London et al., 2005). The difference between high prevalence and low disclosure rates suggest that the majority of young CSA survivors never come to the attention of child protection services.

Participation rights of young people

In addition to the right to confidentiality, the UNCRC (1989) recognises children as autonomous with the right to have a voice in matters that affect them, and have their opinions heard (Lundy, McEvoy & Byrne, 2011). Children are progressively being recognised as experts in their own lives (Bergström, Jonsson & Shanahan, 2010) and increasingly involved in research as active participants (Hunleth, 2011). It remains difficult for young people voices

to be heard though, due to different views regarding competence, protection, and consent. In the UK, children are deemed competent, if judged able to understand decisions they are making (Gillick, 1986). If deemed Gillick competent, they can provide their own consent to medical treatment or research, but, there is then the matter of who judges competence.

Development psychology has also tended to undervalue the competency of children, meaning they have not been taken seriously or believed (Morrow, 2008). Yet, research has shown very young children, for example, with diabetes, able to understand, and control sugar intake, and manage their illness, showing considerable maturity and competence (Alderson, Sutcliffe & Curtis, 2006). This is not new, with James (1995) suggesting researchers see children comparable to adults, but with different capabilities e.g. curiosity and playfulness, and skilled in different methods of communication such as text talk and social media.

Method

This review explored studies that included young CSA survivors unknown and invisible to child protection services and is the first with the dual focus on this population of survivors and their views on confidential services. Young people are defined as under the age of 18 in accordance with the UNCRC, 1989.

A systematic search of seventeen social work and nursing databases was conducted and eleven journals hand searched using the same keywords. Editorials were viewed to identify areas of interest and further key words. Key words and phrases were: confidential; privacy; autonomy; child; sexual abuse; victims, adolescents; teenagers; views; young people; health services; rights. Additional phrases used to filter and narrow searches included; adolescent's perspectives; violence; autonomy and abuse survivors.

Searches were refined by reading titles, and for those that seemed relevant the abstract was read followed by full text. Searches were conducted over 16 months using targeted searches to identify literature from different sources in one database then working

systematically through each database in turn. This procedure was then repeated using different key words with similar meanings such as child, young person or adolescent. After extensive searching, only a few studies were identified. Due to the limited number of studies found, the search was widened to include other types of abuse, not just sexual abuse, and the views of young people about abuse.

Due to the paucity of literature, the search was further widened to include studies about young people's views of school-linked sexual health services. The rational for widening the search to sexual health services was because providing these services to young people seems to be widely accepted to reduce pregnancy and infections (Ingram & Salmon, 2010) and, according to Murray, Thomas and Rogstad (2006), confidentiality of these services is vital. While CSA survivors rarely disclose abuse during childhood (Smith et al., 2000; Priebe & Svedin, 2008), they may attend confidential sexual health services out of necessity (Senn, Carey, Vanable, Coury-Doniger & Urban, 2006). According to Rogstad and Johnston (2014), CSA survivors may continue to use sexual health services even when disengaged from other services. Young CSA survivors can be identified through sexual health clinics (Lederer & Wetzel, 2014) and sexual health services have an important role in identifying CSA survivors (Spencer-Hughes, Syred, Allison, Holdsworth, & Baraitser, 2017). All of this is suggestive of young CSA survivors using sexual health services.

Widening the search increased the keywords to include sexual health clinics; school-linked services, and sexual health in schools. As studies were identified they were added into the database, read thoroughly and data extracted relating to authors, year, methodology, population, country, themes and outcomes, findings, limitations, and sample sizes. An exploratory interpretive approach was used to analyse qualitative data that was thoroughly read, re-read, coded and grouped to establish emerging themes (Dixon-Woods, Agarwal, Jones Sutton & Young, 2005). Data was repeatedly re-analysed to ensure thorough analysis

and explore key concepts to develop a deeper understanding The results section provided quantitative and qualitative analysis, the latter supported by quotations. The approach was reductive in nature and included information retrieved from all methodologies. Emerging themes were compared and categorised until a refined list of young people's views emerged.

The quality of each study was analysed by checking objectives, design, sample-size, methodology, analysis and whether a pilot was completed. According to Barnett-Page (2009), these criteria are good indicators of quality. Although no studies were excluded based on quality (Thomas & Harden, 2010), emphasis was given to the more robust studies to help inform themes (Barett-Page, 2009). Limitations to papers were considered in detail. Studies were excluded if: they did not give young people's views;; studies were not in English; young survivors were in therapy, care or involved with child protection agencies; or studies included only professionals, parents or teachers views.

Results

The aim of the review was to identify the views of young CSA survivors, unknown to child protection, about confidential services. The search initially identified only two studies (1, 2), which fitted the criteria (see Table 1). These studies involved sexually abused young people who were able to give their views within a confidential setting. Only one study (1) fully fitted the criteria in that the young people chose to be involved in research, while the other (2) was a study of data obtained from calls to a confidential helpline.

Widening the search to include all forms of abuse, identified three more studies (3, 4, 5) and further expansion to include school-linked sexual health services identified a further six papers. Four more studies were retrieved after searching references. This provided 15 studies (see table 1) for the current review. One study was published in 1990 and all others between 2000 and 2017. Ten were from Europe, two USA, one Canada, one Hong Kong and one Sri Lanka. Sample sizes ranged between 9 and 2986 and the age range was 5-25 across

studies. All studies except for two (10, 11) involved equivalent numbers of males and females.

Methodology of studies

Interviews (*n* = 4), surveys (*n* = 9), focus groups (*n* = 6), and analysis of pre-existing data (*n* = 2) were used in the studies, with little involvement of young people in design, data collection or analysis. Different methods gathered qualitative and quantitative data, with four studies using a mixture of both. Papers 1-5 were young people's views about abuse and papers 6-15 were views on school-linked sexual health services. Six studies were qualitative (1, 2, 3, 5, 11 and 14) and five were quantitative (4, 9, 10, 12, 13). Four (6, 7, 8, 15) involved both quantitative and qualitative methods.

Nine studies (4, 5, 6, 7, 8, 9, 11, 12, 13) were conducted in school settings. Studies carried out in school can be convenient but only involved those in school that day but also, when carried out in exam like conditions (4), during a lesson (7) or by professionals (12, 13), it is possible that young people might give answers they believe are expected rather than actual opinions. One study (14) was conducted in the community and two studies (10, 15) were held within sexual health services. In short, the range of research methods was narrow, variety of locations limited and the participation of young people was very low.

Several studies had sampling issues. For example, in study (1) participants were reached through advertisements in a girls magazine inviting young survivors to phone. This limited participants to mainly girls reading this magazine. Similarly, study (2) only involved desperate young people calling a helpline. Data in study (3) came from a school-based abuse prevention programme evaluation providing brief information but lacking context, though young people were involved in design, data collection and analysis of other young people's

data. The study with young mothers (11), was small, and focused on the agenda of ensuring the mothers did not get pregnant or catch infections, rather than hearing their views.

Three sexual health studies (6, 7, 13) were broadened to get views of young people in schools, though one study limited this to 13-15 year olds. Those studies focusing on children in school (4, 5, 8, 9, 12) chose different selection methods, with one randomly selecting from the school register (4), another selecting based on language ability (5) and two selecting by year group (9, 12). This made comparisons of the studies challenging.

Four studies were small, (1, 5, 11, 14), making it difficult to generalise results. Several studies were restricted to specific populations, such as survivors of abuse (1, 2, 3), young mothers (11) or service users (2, 10, 15). Of studies that used surveys, only four piloted it (4, 8, 12, 13). Surveys might have been more reliable if piloted, and focus groups could have provided greater insight if larger. Studies were carried out by adult researchers but more involvement of young people in data collection and analysis might have enhanced them.

Analysis of themes

Themes identified from studies were: confidentiality, participation, information, shame and blame, control and fears, accessibility and someone friendly and confidential to talk to. This study was specifically seeking young people's views on confidential services, therefore, confidentiality was a key issue in identifying studies.

Confidentiality

Confidentiality was assured in three studies (1, 6, 13) and, due to the nature of data collection, implied in five studies (4, 7, 8, 9, 10). Two studies required parents and school consent (11, 12) though in one (12) young people were reassured their answers would be confidential (12). In three studies (5, 11, 14) there was no mention of anonymity. In two studies (2, 3), data were already anonymised. Participants in three studies (1, 2, 3) sought

confidentiality by utilising confidential services. The confidentiality guaranteed by the study method (1, 3) or service (2), gave young people confidence to talk openly without fear. For those able to talk directly to someone (1, 2), it meant the opportunity to receive information and disclose safely. For those (3) who disclosed anonymously, there was a sense of relief, "maybe you just want to like get it out somewhere and you don't know where else to talk about it" (3, p. 705).

Some studies rated confidentiality (12, 14) as the most important factor when seeking help for sexual health. One study (9) rating it as the most important factor 56% (n = 166). Fear of being seen attending a service (13, 14) and anonymity were so important that services were wanted located within a facility (14) providing a range of services. This was echoed in one study where young people (6) were concerned about people listening, then telling others what they had overheard, or gossiping (7) about who they had seen attending clinic. Some were concerned (7) the clinic could be seen from the staff room.

Rural young people (14) had concerns regarding confidentiality, as service providers would know parents and family. "Even the ladies on reception, you'd be afraid that they would know what you are going in for" (Female, 14, p.291). Due to transport problems, young people could not travel but thought staff brought in from outside might help with confidentiality. They highlighted problems at chemists where local people could guess why a prescription was dispensed. While some chose services because they were confidential (1, 2, 13, 15), others were concerned (15) people could see who attended local clinics.

One study (9) asked young people directly about confidentiality and found if confidentiality was compromised, young people would not use services or would be untruthful. Additionally, 80% (n = 236) thought a GP should not tell child protection services about a young person at risk, while 63% (n = 186) would not attend the clinic if they knew the doctor would inform child protection services. In some studies (6, 13) there was

confusion about how confidential services actually were, (13). To summarise, confidentiality and anonymity were important and key factors in determining young people's use of services and ability to talk openly.

Choice of participation.

In four studies (1, 7, 8, 15) young people could choose involvement through phoning for interview (1), returning a questionnaire (7), joining a focus group (8), or accepting an interview (15). Two focus groups were formed with young people who chose participation (6, 8); in two studies, young people were invited to be involved (7, 14).

Surveys involved different degrees of choice of participation. When conducted in school under exam condition (4) or during lessons (6, 8, 9, 12), young people were potentially less likely to refuse, despite being told they could opt out (6). In one study, young people (13) were given the survey away so had greater choice over whether they wanted to participate. Those being interviewed (1, 7, 15) made an active choice through answering advertisements. Those whose data was provided to researchers (2, 3) for anonymous documentary analysis, had no say. In brief, choice to participate varied across the studies.

Someone friendly and confidential to talk to.

The importance of staff being friendly (7, 8, 10, 11, 12, 13, 14, 15) and non-judgmental (1, 6, 7, 8, 10, 11, 14, 15) was highlighted but was linked to confidentiality. In two studies (12, 15) friendly staff was rated as the most important factor when seeking help. Young people said they attended clinics (7, 10, 13, 15) because of friendliness and non-judgmental attitudes of staff, but needed time to build trust (6). In the study with abuse survivors (1), two thirds said they needed someone to talk to in confidence who could listen, be friendly, supportive, and non-judgemental. This was echoed in other studies in which young people (1, 4, 10, 11, 12, 14, 15) needed someone to talk to in order to reduce isolation (4). The need to be believed (2, 3) was important for abused young people. "Abuse happens

so much and people deny that it is happening and don't really listen to the victim. I was abused and I know how it feels when people don't listen" (3, p 705). In study (2) approximately one-third were not believed when they disclosed abuse, which was similar in other studies (1, 3) when trying to tell.

Young people (1) felt isolated and wanted someone to talk to in confidence (4, 10, 11, 12, 14,15). They expressed a need to be heard, speak out, share feelings and share the burden of the secret with someone (1). "….I wanted to try…to talk….maybe I've understood that other people have experienced this…and I've decided to talk." (Fabrizio, age 17, 1 p.1040). Having someone, other than a professional, to talk to was also important (12).

Several studies (2, 3, 4, 10 & 12) indicated young people would turn to friends or family for help, rather than professionals. Indeed, friends emerged as one of the main sources of support for young survivors. Half the young people in the survivor study (1) talked to a total of 35 relatives and most got help, with some helping stop abuse. In some cases, talking to friends helped them access services (10), and in one study (3) young people reported liking to help other young people In summary, it was highlighted that isolated young people need someone to talk to in confidence, friendly non-judgement staff and peer support for advice and information.

Need for more information.

Several studies mentioned the need for more information (1, 3, 10, 11, 12, 14, 15) about services and education (4) into causes and effects of abuse, and importance of telling. One study (3) mentioned young people having no knowledge of abuse. Studies mentioned receiving information from friends (10), lack of awareness of services (14) or what they provide (1, 14), and having wrong information. Some did not know what abuse was (1, 2, 3) and wanted to access information about it through school talks and posters (12).

Sexual health information was regarded as important but nearly half who expressed an opinion (*n* = 156) stated they could not ask questions of teachers during sex education lessons in school (12). Young people in two studies (12, 14) believed they should receive sexual health information at a younger age to make informed choices and protect themselves, "I feel as if I didn't receive very good information from primary or secondary school…I now take contraception more seriously after finding out I was pregnant and having an abortion." (12, p.376) Sexually active young people (12) wanted sexual relationships, contraception, abortion and abuse taught at a younger age. Half the young people (12) were unaware that sex with anyone under 16 was illegal and over half unaware that a girl under 16 can receive contraception without parental consent. In brief, accurate information about sexual health and abuse at a younger age was highlighted as necessary for health and decision-making.

Shame and blame.

Young people in three studies (1, 2, 14), spoke about embarrassment, shame, and self-blame. Abused children (1, 2) felt guilty and believed they had caused the abuse. "Since it happened, I have always thought it was my fault. Then I wondered if my behaviour had made him think…maybe" (Marina, age 16, 1 p.1040) Even when the survivor accepted she was not to blame (1), it was still considered shameful, and some believed professionals might blame them. For some who reported abuse to authorities, the abuse was minimised and they were indeed blamed. Being able to talk in confidence to someone reduced shame (1, 2). Similar feelings of self-blame and embarrassment were described by young people using sexual health services and this impacted on how they used services (14). In summary, shame, embarrassment and self-blame were an important factor for young people needing confidential services.

Control and fears.

Staying in control (3, 6, 8, 15) and going at their own pace (3) was important and this required services to remain confidential. Similarly with sexual health services, young people wanted control (6), with over half (n = 163) of 11-14 year olds, and one third (n = 142) of 15-18 year olds (8) saying control was important. The difference in figures could be attributed to older young people feeling more able to remain in control than younger people. Being treated like an adult (15) helped young people feel confident, in control, and better able to make informed decisions.

Confidentiality was needed because young people feared consequences (2, 3, 5, 6) of people finding out. They mentioned abusers' threats to abuse other people, and feared abuse would escalate (1, 2). Five studies (1, 2, 3, 4, 5) had concerns about abuse for family members. A quarter (n=8) of young people in one study (1) wanted to protect family from negative consequences, particularly when parents faced adversity. One young survivor stated, "My parents are divorcing and I don't want to be another burden to them" (Elisa, age 15, 1 p.1042). Some were concerned about the abuser (2). Loyalty to family (3, 5), fears of betrayal and of consequences all contributed to remaining silent about abuse. Protecting family from knowledge of abuse and outsiders from knowing about abusive family members (5, 14) were reasons not to disclose. Other studies (6, 7) highlighted concerns of family finding out they were using services with fear of over-reaction. There were also cultural issues for young Muslims unable to risk families seeing them enter sexual health services (7).

Many distrusted authorities, regarding child protection as intrusive (3, 5, 6). In one study (3) there was high expectation, whether justified or not, that child protection interventions would be ineffective or over reactive. "I've been in an abuse situation before but now am a ward of court and will be 18 soon. I think sometimes when an abuse situation is turned over to welfare it can ruin the child's life in some ways, because the social workers keep bringing up the situation like they did with me, taking me out of school to talk about it

and sending me to a psychiatrist when it was embarrassing me and making me feel singled out" (17 year old girl, 3, p. 705) There was fear of overreaction (6), being referred to social work, and fear of authorities leading to everyone knowing their private information (5). Some young people who had been abused by peers feared their freedom might be restricted (1). In conclusion, young people described the importance of confidentiality in retaining control over their lives, fear of the negative consequences of disclosure and distrust of authorities.

Accessibility of services.

Frustration was expressed (3, 12, 14, 15) about opening times, with some (6) open one hour a week. Many wanted clinics to open weekends and after school (8, 15) with clinics close to public transport (8), and offering drop in (12, 15). Young people (12) could not access more distant services without their parents' knowledge or those only open during school hours. One study (15) found that young people chose a service due to its location near to home and school, coupled with a drop-in facility. The drop-in was vital and young people preferred waiting, to making appointments. Poor advertising (14) of services meant young people were often unaware of their existence (1). "Well I had to ask to find out where there were any locally, like I hadn't a clue" (Female, 14, p.291). Services therefore needed to meet young people's needs for accessibility, confidentiality and be better advertised.

Discussion

The current review identified the paucity of literature on young CSA survivors, unknown to child protection services, perspectives about confidential services. Broadening the focus from CSA to sexual health studies increased the number of studies for analysis.

Conceptually, the themes identified from the studies in the review focused on children's experience of the use of confidential services. Fear of not being believed, feelings of shame and self-blame and loss of control are common themes identified by adult survivors who never disclosed to child protection services (Goodman-Brown et al, 2003). But, for

young survivors unknown to services, the themes of needing someone to talk to, fear of consequences, and loss of control were all linked to confidentiality, with young people expressing the need to have someone to talk to in confidence, so they could stay in control of their lives. Lack of confidentiality prohibited young survivors from talking about abuse and dealing with feelings of shame and blame, and led to a fear of consequences and fear of not being believed. It also, inhibited survivors from getting information.

For young survivors unknown to services, it was clear from the studies that confidentiality was hugely important, and this was supported by young survivors choosing confidential helplines to share problems and disclose in a safe, and confidential space. However, there was a lack of clarity for young survivors about what services meant by confidentiality, and there were no reports in studies of any service definitions being provided for young people. Sexual health service users were uncertain about what circumstances would cause confidentiality to be broken. Young people knew disclosing abuse was one circumstance, but young people were uncertain about what and how much information a disclosure involved. Studies supporting this finding indicate that 63% of young people would not use sexual health services, and a further 20% would not be truthful, if child protection agencies were informed (Thomas, Murray & Rogstad, 2006). Furthermore, the study in which 80% of young people thought that GP's should not report suspected risk to child protection services suggests a lack of trust in child protection. This is a serious issue to be better understood and addressed for the safety and protection of young people.

Studies methodological weaknesses

Only one study tried to involve young people in analysis of data. Methods used were not inclusive of young people as social actors, but were traditional in using surveys, interviews and focus groups. Children have a right to have their opinions heard (Lundy, et al., 2011). It would seem, that young people participating more actively as researchers is a major

research gap in seeking to understand their views on confidential services. Lundy and colleagues (2011) argue that better outcomes are obtained by involving children in research, as child researcher findings are rooted in perspectives of young people. This is echoed by Bergström et al. (2010), who found children to be knowledgeable and competent researchers. However, Kellett (2005) cautions that, as research involving children as researchers is likely to increase, there are issues to be addressed before academics will receive and value such research. These include protection, training, power, balance of insider/outsider perspectives, competence, and ensuring that research involving children is ethical.

Limitations of the current review

Studies involved young CSA survivors unknown to the child protection services. Those survivors who disclose abuse in childhood might hold a different view to those who do not. However, without a comparison of the literature involving those who disclose, and those who do not, this remains an assumption. The search criteria was widened to include young people's confidential sexual health services, however, it was not possible to determine how many young people in these studies, if any, might have been sexually abused due to young survivors knowing they will lose confidentiality of these services if they disclose abuse. Searching other databases and journals with different keywords might possibly have yielded different results too. Finally, the limited literature resulted in analysing a diversity of studies and analysis of the views of young people across sexual health service, sexual abuse, and other abuse. As such the authors are cautious about the specificity of conclusions to young people who are sexually abused.

Conclusions

The current review identified confidentiality as a significant issue for young survivors unknown to child protection services. Studies indicated that the parameters of confidentiality from services were often ambiguous. The importance of being believed, having someone

non-judgemental, and confidential to talk to, along with time to build trust were recurring findings. Analysis of studies suggested a mistrust of authorities, fear of consequences, lack of information, shame, embarrassment, and fear of losing of control, inhibited young people from talking to child protection services. Instead, young people preferred support and information from friends and relatives. Methodologically, the review found that few studies asked young people's views on confidentiality and none involved active participation as researchers. For those studies that did seek young people's views, methods used covered a narrow range of traditional approaches.

Recommendations for research

It is currently premature to give recommendations for policy and practice without empirical research. The current review along with previous adult survivor prevalence studies, however, suggests that a review of current levels of service guidance on confidentiality be re-examined. Empirical research is needed into the views of young CSA survivors, unknown to child protection services, on confidential services. Future research also needs to consider the various levels of young survivor involvement in research, including survivors as participant researchers. It is important that young people are given opportunity to participate in such research. Additionally, by involving young people as researchers, opportunities to be more creative in methods to gather, share and interpret information, might present.

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Appendix

Table 1

Literature and methodology

No.	*Reference*	*method*	*Size*	*Age*	*Population*
1.	Crisma, M., Bascelli, E., Paci, D. & Romito, P. (2004). Adolescents who experienced sexual abuse: fears, needs and impediments to disclosure. *Child Abuse & Neglect.28*(10), 1035-1048.	Qualitative phone interviews	36	12-22	CSA survivors
2.	Jackson, S., Newall, E. & Backett-Milburn, K. (2013). Children's narratives of sexual abuse. *Child and Family Social Work, 20*(3), 322-332.	Qualitative data analysis	2986	5-18	CSA survivors
3.	Ungar, M., Tutty, L., McConnel, S., Barter, K. & Fairholme, J. (2009). What Canadian youth tell us about disclosing abuse. *Child Abuse & Neglect, 33,* 699-708.	Qualitative data analysis. Focus groups & Interviews	1099	12-19	Abuse survivors
4.	Miles, G., (2000). Children don't do sex with adults for pleasure: Sri Lankan children's views on sex and sexual exploitation. *Child Abuse & Neglect, 24*(7), 995-1003.	Quantitative survey	145	13-17	School children
5.	Chan, Y., Lam, G. & Wan-Chaw, S. (2011). Children's views on child abuse and neglect: Findings from an exploratory study with Chinese children in Hong Kong. *Child Abuse & Neglect, 35,* 162-172.	Qualitative focus groups	87	9-13	School children
6.	Carlson, C. & Peckham, S. (2004). Bringing health care to schools: first phase evaluation of the Bodyzone Project. *Health Education*, 104, 241-53.	Qualitative & quantitative survey, focus group	496	13-15	School children
7.	Ingram, J., Salmon D. (2010). Young people's use and views of a school-based sexual health drop-in service in areas of high deprivation. *Health Education Journal. 69* (3), 227-235.	Qualitative & quantitative survey, interviews	515	10-16	Clinic users, school children
8.	Nwokolo, N,. McOwan, A., Hennebry, G., Chislett, L. & Mandalia, S. (2002). Young people's views on provision of sexual health services. *Sex Transmitted Infection. 78,* 342-345.	Qualitative & quantitative survey, focus group.	744	11-18	School children
9.	Murray, E., Rogstad, K. & Thomas, N. (2006). Confidentiality is essential if young people are to access sexual	Quantitative survey	295	14-15	School children

	health services. *International Journal of STD & AIDS. 17*, 525-529.				
10.	Bar-Cohen, A., Lia-Hoagberg, B. & Edwards, L. (1990). First family planning visit in school-based clinics. *Journal School Health. 60*, 418–22.	Quantitative survey	144	14-17	Female sexual health services users
11.	Schaffer, M., Jost, R., Pederson, B. & Lair, M., (2008). Pregnancy-Free Club: a strategy to prevent repeat adolescent pregnancy. *Public Health Nursing. 25*, 304-11.	Focus groups	9	15-22	Female sexual health services users
12.	Reeves, C., Whitaker, R., Parsonage, R., Robinson, C., Swale, K. & Bayley, L., (2006). Sexual health services and education: Young people's experiences and preferences. *Health Education Journal 65*(4) 368-379.	Quantitative survey	260	15-16	School children
13.	Davies, C., Kay, C., Morgan, D., Tripp, J., Davies, C. & Sykes, S. (2006).To what extent are school drop-in clinics meeting pupils' self-identified health concerns? *Health Education Journal. 65*, 236-51.	Quantitative survey	590	11-17	School children, sexual health clinic users
14.	Donnelly, C. (2000). Sexual health services: a study of young people's perceptions in Northern Ireland. *Health Education Journal*, 59, 288-296.	Qualitative focus groups	26	15-25	Young people
15.	Hayter, M. (2005). Reaching Marginalized Young People Through Sexual Health Nursing Outreach Clinics: Evaluating Service Use and the Views of Service Users. *Public Health Nursing*, *22*(4), 339-346.	Qualitative & qualitative survey, Interviews	166	13-18	Sexual health clinic users